TAX CREDITS/VOUCHERS TO INCREASE EMPLOYMENT BASED COVERAGE

(Appendix 1)

Overview

California has a low rate of employment based coverage, especially in comparison to the rest of the country.[1] In 1999, Californians were 6.6 percentage points less likely to receive employment based health insurance than the average American.[2]

Employment based coverage is the dominant form of coverage for working Californians. Employment based coverage is purchased with a pre-tax dollar and encompasses a series of significant cross subsidies from younger to older, healthier to sicker and higher wage to lower wage workers.[3] The tax subsidies for employment based coverage do not assure affordability for those employers with a high percentage of low wage employees. Pre-tax purchasing of employment based coverage subsidizes about a third of the cost of employment based coverage and up to half the costs of coverage for high wage earners.[4] It is poorly designed to provide affordable coverage for low wage workforces, as it subsidizes less than 10% of premiums for low wage workers. As a result the average cost of coverage for an individual employee is over 20% of the wages of a minimum wage employee and the average cost of family coverage is over 50% of the annual wage of a minimum wage workers.[5] See Charts 1 and 2 attached.

For the most part California's uninsured are young, low-income workers; 65% are under age thirty; over two-thirds have incomes under 200% of the federal poverty level; and over 80% are employed or dependents of an employee.[6] Latinos, young adults and immigrants have very high ratios of uninsured (over 40%), high workforce participation rates and face federal and state obstacles to participation in public programs.[7]

In general enrollment through the workplace is easy; employee participation rates are high even for low wage workers, and coverage is highly valued.[8] California's non-citizens work long hours for low wages, and frequently without health insurance; nearly half are uninsured.[9] Restrictions on public coverage for many of the state's immigrants place a premium on developing alternative basic affordable private coverage through the work place for immigrant workforces -- the working backbone of many segments of California's economy.[10]

California has a broad range of industry types, which differ widely by average firm size, average pay and the rates at which they offer health coverage. Retail trade had approximately the same wage levels as reported for agriculture, but a far higher rate of employer offering.

EMPLOYMENT, PAY and OFFER RATES[11]

Type of industry	Number of establishments	Average monthly employment	Average annual pay	Rate of offering by industry type[12]
Agriculture	37,000	509,000	$18,000	46%
Construction	70,000	680,000	$37,000	61%
Manufacturing	57,000	1,915,000	$50,000	85%
Transportation and utilities	31,000	706,000	$46,000	90%
Wholesale trade	72,000	811,000	$46,000	78%
Retail trade	165,000	2,387,000	$20,000	71%
Finance, insurance and real estate	76,000	817,000	$55,000	86%
Services	500,000	4,352,000	$37,000	74%
Federal government		271,000	$45,000	99%
State government		391,000	$42,000	99%
Local government		1,505,000	$37,000	99%

We reviewed wage compositions for two industries, with below average rates of offering coverage: the construction industry and the services industry. Within the construction category, there was a relatively narrow variation in average pay by type of construction firm.[13] The construction industry has a large proportion of very small employers and a high rate of employees shifting from job to job.[14] The services category encompassed a wide range of industry types with wide variations in average pay and firm size as displayed below.

SERVICE INDUSTRY, PAY and EMPLOYMENT[15]

Type of industry	Number of establishments	Average number of employees	Average monthly employment	Average annual pay
Hotels and motels	5,800	32	187,000	$20,000
Beauty shops	8,000	4.5	36,000	$14,000
Building maintenance	5,800	15.5	90,000	$15,000
Automotive services, except repair	4,000	10	41,000	$17,000
Motion pictures	12,000	16.6	200,000	$55,000
Hospitals	984	334	329,000	$38,000
Legal services	22,000	5.5	121,000	$65,000
Educational services	7,000	26	183,000	$29,000
Child day care	7,000	7.5	53,000	$16,000
Engineering and management services	47,000	9.4	442,000	$58,000
Private households	173,000	.9	151,000	$10,000

There is a reported difference between the offer rates of construction, durable manufacturing and non-durable manufacturing.[16] As displayed above, manufacturing has larger average firm size, higher average annual pay and a higher offer rate than the construction industry. We reviewed average hourly wages and hours worked between construction and manufacturing and within the manufacturing sector. Construction had higher hourly pay rates and lower hours worked; we assume construction also has fewer weeks worked annually than manufacturing due to shifting job sites. Durable and non durable manufacturing each included industry types with higher and lower rates of pay. The apparel industry had particularly low rates of pay.

WAGES in the CONSTRUCTION and MANUFACTURING INDUSTRIES[17]

Type of industry	Hourly rate	Average hours worked
Construction	$23.02	36.7
Manufacturing	$15.32	40.6
Durable		
Lumber and wood products	$12.02	40.9
Furniture and fixtures	$11.04	38.7
Computer and office equipment	$18.98	39.4
Motor vehicles	$18.55	41.9
Aircraft	$21.33	42.9
Non durable		
Meat products	$10.68	42.7
Apparel	$8.98	39.4
Petroleum refining	$28.04	45.3
Movie production	$33.71	34.9

We reviewed the composition of California's workforce by employer size and wages:

- 11% work for employers of less than 10, (where reported offer rates for health coverage are less than 50%)
- 27% work for employers from 10 to 50 employees,
- 30% for employers from 51 to 250 and
- 32% for employers with 250 or more employees (where reported offer rates for coverage are about 100%). [18] See Chart 3 on offer rates by firm size attached.

Mean wages in California are $18 an hour; the 25th percentile is $9; the 75th percentile was $23 in the year 2001.[19] California's minimum wage is $6.25; about one million workers (about 8% of employees) made the minimum wage or less in 1999. Half of minimum wage workers are under age 25, and two thirds are younger than 35. Nearly half of minimum wage workers are Hispanic; Hispanics had the highest reported rate of minimum wage workers -- 15%.[20]

The reported offer rates for health coverage were 58% for employees making less than $9.50 an hour, 87% for employees making between $9.50 and $14.25, 89% for employees making between $14.26 and $19.00 and 95% for employees earning more than $19,00 an hour.[21] In 1999, the highest 10% of salaried workers made $30 an hour or more. One third of the state's workers make wages of less than $12.50 an hour or $25,000 annually.[22]

Poverty Levels and their Relationship to the State Minimum Wage[23]

Poverty level family of one	Poverty level family of two	State minimum wage	Poverty level family of three	Poverty level family of four	200% of poverty family of one	200% of poverty family of two	Twice state minimum wage	200% of poverty family of three
$8,950	$11,610	$12,500	$14,630	$17,650	$17,900	$23,220	$25,000	$29,260

California has experienced increases in health coverage “offer” rates by small employers, and more low wage workers are now receiving private coverage through their employers. This is due to rising wages, not to increasing offer rates for low wage workers. The offer

rate did not improve (in fact it declined) for low wage workers.[24] Many predict that employment based coverage will again decline in response to rising health plan premiums and the slowing economy.[25]

California's uninsured are concentrated among smaller and predominantly low wage workforces.[26] California's low wage workforces and small employers need both effective group purchasing[27] and premium subsidies efficiently targeted to the uninsured.

REFUNDABLE TAX CREDITS/VOUCHERS TO INCREASE THE OFFER RATE FOR SMALL EMPLOYERS WITH LOW WAGE WORKFORCES

a. Research

California's offer rates for very small businesses (10 employees or less) are particularly low -- about 50% as compared to nearly 100% offer rates by large businesses. Average pay steadily increases with firm size; the smallest average pay was for employers of 5-9 employees, and the largest was for employers of over 1000 employees; the pay differential was about 50%.[28]

Offer rates (about 20%) for small employers (2-200) with a high percentage of low wage workers (full time workers making less than $20,000 annually) were one third the reported offer rates for all employers.[29] A tax credit targeted to this group of employers could be cost effective if substantial numbers of the firms not now offering coverage can be induced by the subsidy to initiate coverage. See Charts attached.

Uninsuring employers report that the primary reasons that they do not offer coverage are affordability, affordability, and affordability.[30] While no definitive research has been done to quantify the response of employers to different levels of subsidy, the employer and employee responses to Sharp Health Plan's Focus product (which has a 50% premium subsidy) have been very strong.[31]

If we fail to increase employer offer rates for low wage workers in California, government's 100% cost of care and coverage will be substantial. There are a number of options a state can use to increase employment based coverage. These include public program buy ins, premium subsidies through purchasing pools, health plan subsidies either in the form of reinsurance or relief from state mandates on covered benefits and refundable tax credits. None of these approaches has been more notably successful than the others. Iowa has had the most successful public program buy in (8500 participants), and Arizona had success with reinsurance (3610 small firms). Kansas reported 62 newly insuring firms responding to a small employer tax credit and Massachusetts reported 800 firms small firm enrolled in a premium subsidy program.[32]

States such as Washington (130,000 enrollees), Minnesota (117,000) and Wisconsin (65,000) have had strong success with individual enrollment in premium subsidy programs, but report very little employer take up of employer premium subsidies.[33] Local plans in Wayne County, Michigan (1,977 small businesses), San Diego (216 small businesses) and Muskegon County, Michigan (155 small and midsize employers) have reported substantial success in attracting employer enrollment. The philanthropic

premium subsidy for FOCUS in San Diego was 50% while the two Michigan sites had 33-40% public premium subsidies.[34]

CSBA (California Small Business Association) has conducted survey and focus group among California's small employers, which indicates that small employers are significantly more receptive to refundable tax credits than to MediCal program buy ins and were typically unaware of the Healthy Families program.[35] There are ranges of approaches introduced in the California legislature to provide public subsidies to increase employment based coverage; they divide between tax credits and employer premium subsidies through a purchasing pool.[36]

California has two purchasing pools for small employers each with about 150,000 enrolled lives. Most small businesses are unaware of the pools, and their penetration in the small employer market has been less than expected.[37] Distributing premium subsidies to employers through existing purchasing pools is appealing due to the administrative efficiencies, but it may fail to reach most of the employers we would wish to target because participation rates in the existing pools are a small percent of the market.

b. Premium subsidy

Employer tax credits have to be set at high enough levels to cover a substantial portion of the cost of coverage in order to induce participation by uninsuring employers,[38] and allow low wage employees to take up employer coverage. Challenges include: 1) calculating the size of the credit sufficient to induce offering; 2) designing a sufficiently targeted tax credit to be an efficient financial vehicle to increase employment based coverage;[39] 3) making it simple enough for small employers to use without access to sophisticated tax accountants; and 4) timing the credit to meet employers' premium payments. An unappreciated advantage of a well targeted employer tax credit is that it reaches uninsured workers not otherwise eligible for federal and state public programs and has radiating impacts -- i.e. the employer offers coverage for those with the credit and those without.

ITUP's proposal is that the premium subsidy (via refundable tax credits or vouchers) should be 50% of the premium. We selected that level because it has been successful in San Diego and is the current tax subsidy for the best paid employees. The Michigan pilot sites appear to have had enrollment success with 33-40% premium subsidies however the Robert Wood Johnson pilot projects had less success with 10-25% premium subsidies.[40]

The targeted subsidy would be 50% of the premium for those employees making less than twice the state's minimum wage. For employees at twice the state's minimum wage, the average cost of family coverage is slightly under 25% of wages and the average cost of individual coverage is slightly less than 10% of wages. This targets the premium subsidy to those employees with the highest degree of unaffordability and least subsidies through pre-tax purchasing.

The premium subsidy should be carefully targeted and equitable i.e. it must focus on increasing employment based coverage where offer rates are low and treat new offerors

and current offerors the same. A tax credit would be most cost effective if targeted to uninsuring small employers; however it creates a serious equity issue to subsidize a non offering employer while excluding its competitor down the street who already offers coverage. Focus groups and workshops on this issue conducted by California Small Business Association indicate that "equity" will be essential in explaining tax credits to small employers.

We recommend targeting subsidies to those employers with from 2-250 full time equivalent employees where at least a third of the workforce earns wages of less than twice the state's minimum wage ($12.50 an hour). The research suggests that only 20% of employers of less than 200 employees with at least a third of their workforce making less than $20,000 annually offer coverage. [41] However as will be discussed, a large universe of employers meets this definition.

Our research found that one third of the state workforce makes less than $12.50 a year and two thirds of all workers work for employers of less than 250 employees. We were not able to determine the numbers of employers meeting our proposed target definition. The Employment Development Department indicates that it maintains and reports data by employer size and average wages, but they do not maintain and report data that indicates the wage composition of a given employer's workforce. [42]

Ninety nine percent of all California employers have fewer than 250 employees and two thirds have fewer than 10 employees. Since offer rates and average wages increases with firm size, we considered setting the employer cut off size at 10 or at 50 employees. We recommended the larger definition of employers of 250 employees or less in order to reach mid sized employers with large numbers of low wage uninsured employees. Setting the target size too low may reach too few of the uninsured and create undue incentives to stay small. [43] However it would be more cost effective for California to target employers of a smaller size.

We investigated setting the subsidy target for those employers with low average wages. For example the agriculture industry's average wages were only $18,000 annually ($9.00 and hour). However half of agricultural employers already offer coverage. Targeting the subsidy by average wages would be equitable but would be less cost effective than our suggested target.

We considered and then rejected targeting employer subsidies by the employee's family income. Thirty percent of all Californians have incomes below 200% of FPL and this group of employees has the highest rate of lack of coverage. Employers, however, do not know family income, and this is not information that employees would want shared with their employer.

We propose tying the subsidy to the Knox/Keene basic benefits package with the addition of prescription drugs; this is equivalent to the coverage of virtually all employer plans. [44] Some will argue for fewer benefits so that more plans would qualify and others for more benefits to be comparable to MediCal coverage. We recommend adding prescription

drugs to the Knox Keene basic benefits plan[45] as it is impossible to practice modern medicine without them and impossible for low wage workers to afford prescription drugs out of pocket. The Knox Keene statute setting forth basic benefits does not limit the size of health plan copayments, which could make low wage subscriber's access to services difficult in plans with high patient copays.

Over the years, the Knox Keene Act and the Insurance Code have been encrusted with a series of benefit mandates; these include mandates to offer and mandates to cover specified benefits and mandates to include certain types of providers.[46] We requested estimates of the added cost of these mandates, and one plan with experience in both the self insured and insured markets suggests the added cost is 6% of premium. We recommend no new mandates, a careful review of the health and cost benefits of existing mandates and pilots testing the cost and employer responsiveness to basic coverage without the supplemental mandates.

EDD (Employment Development Department) and FTB (Franchise Tax Board) will need to collaborate to administer the subsidy for most small employers. EDD collects employer and employee payroll taxes, and FTB collects and administers the Bank and Corporations tax and individual income tax. Employers would self certify their eligibility for the credit and be audited and computer cross checked by FTB and EDD for compliance.

EDD and FTB receive information from employers and the self employed quarterly; it is possible therefore to time the tax subsidies from the tax agencies to meet quarterly health plan premiums. However, there is a lag time of up to four months in compiling the tax information for those (mostly small employers) who submit their taxes manually as opposed to those who submit their tax information electronically.

FTB points out that many small employers pay no tax other than the $800 Bank and Corporations tax and that some of the state's self employed pay only the minimum tax. Employers typically also pay sales, property and utility taxes. To reach many of our target uninsuring employers, the tax credit needs to be refundable; this will require a state General Fund Appropriation.

Several small non profit agencies point out that they are typically not benefited by tax credits but have the same health insurance affordability problems as any other low wage small employer. We recommend that they receive a premium subsidy as well in the form of a voucher for 50% of the cost of coverage of their low wage employees.

Both state tax agencies point out that refundable tax credits can and have posed fraud problems. One potential solution is to make the refundable tax credit in the form of a voucher, which can only be used by the employer to purchase basic health plan coverage. This obviates the need to cross check the employer's purchase of basic health coverage.

EDD points out that it collects the Unemployment Insurance (UI) and State Disability Insurance (SDI) taxes which are dedicated to those programs. This proposal does not suggest a rebate of either the UI or SDI taxes.

FTB points out that many small and mid sized employers are subsidiaries of larger corporations. FTB is able to distinguish between small business subsidiaries and stand alone small employers; we do not recommend subsidies for coverage offered by subsidiaries.

Ideally the health insurance premium subsidy should phase down and out as businesses grow in size and wage levels improve. We concluded this is too complex to design and model for the purposes of this paper.

We recommend that the approach should be thoroughly reviewed after three (five) years to determine its cost efficiency[47] at covering uninsured workers and include a sunset if a targeted increase in employment based coverage is not achieved.

REFUNDABLE TAX CREDIT/VOUCHERS TO INCREASE THE TAKE UP RATE BY LOW WAGE WORKFORCES FOR FAMILY COVERAGE

(Appendix 2)

A. Research

California has lower levels of employee contributions ($20 per employee per month for employee only coverage and $113 per month for family coverage) and a higher take up rate (nearly 90%) than the national averages.[48] Family coverage is typically three times as costly as employee only coverage, and employee premium shares are usually a higher percentage of family than individual coverage.

The projections are that employees' share of health premiums will increase as health costs rise faster than wages, profitability declines, unemployment increases, and the economy moves into a recession.[49] The California Budget Project reports that average wages for low and middle income Californians fell after adjustment for inflation from 1989 and 2000, and that low and middle income employees worked significantly longer hours to make up for the decline in their hourly wages.[50] Medoff et al. point to a two decade long squeeze on wages, benefits and increasing shares of premiums for low wage workers.[51]

There may be as many as one million uninsured Californians who are offered coverage but decline it.

- In 1996, 17% of uninsured persons with incomes below poverty were offered but declined employer sponsored health insurance and
- 28% of the uninsured with incomes between 100 to 200% FPL were offered but declined employer sponsored health insurance. [52]

Several commentators have pointed out that declines in employee take up rates of offered coverage were offsetting gains in employer offer rates.[53] These trends may be exacerbated during the recent economic slowdown.

Does California have an affordability problem for low wage employees? We calculated employee premium contribution averages as a percent of employee incomes. We used two standards of employee wages to calculate affordability: 2% of wages (the AIM contribution schedule) and 3% of wages. At two percent of wages, all individuals making at least the state minimum wage on a full time, full year basis can *afford* the average employee share of individual premiums. In other words, working individuals with incomes above 133% of the federal poverty level do not spend more than two percent of wages on the average employee contributions for individual coverage.

However our calculations of affordability of premiums for low income working families produced very different results. Using 2% of family income as our benchmark, working families with incomes below $60,000 experience affordability problems. Using the 3% of family income as our benchmark, families with incomes below $45,000 (which equals the median family income) experience affordability problems. Roughly half of all families in California pay more than 3% of family income for health insurance premiums. Using these benchmarks, California has a very extensive affordability problem for below

median income working families with and without health coverage, but not for low wage working individuals (unless they have incomes below 133% of the federal poverty level). See Chart 6 attached. High income employees have the ability to secure substantial tax subsidies for their share of premiums through an Internal Revenue Code §125 account; due to their low incomes and low income tax rates, low wage earners get little help from this source.

But does this level of an *affordability* problem affect the take up rate for employer offered coverage? Apparently it does, but it does not affect it as much as one might expect. The take up rate falls from 97% for workers making over $19 an hour to 73% for workers making less than $9.50 an hour.[54] A study from the Urban Institute found that California's low wage Hispanics experience an offer problem (i.e. they are not offered coverage), but even the lowest wage Hispanic workers have a high take up rate. These low age working individuals value coverage even in the face of family coverage contribution requirements that may run up to 10% of income.

Urban Institute Findings on Offer and Take Up Rates For Low Wage Hispanic Workers[55]

Offer rate, wages $7.50 or less ($15,000 or less annually)	Offer rate, wages $7.50-$15.00	Take up rate wages $7.50 or less	Take up rate wages $7.50. $15.00
38%	68%	80%	84%

Referring to *average* employee contribution levels masks the affordability problems actually experienced by some low wage working families as not all employers pay the average. A recent study by the California Small Business Association illuminates this problem. Small employers responding to the survey report their typical contribution requirements for employee only coverage are 75-100% of premium; their contributions for family coverage averaged 50%. Small employers reported a bi-polar distribution of contribution levels for family coverage -- 40% of offering small businesses report paying 80-100% of family coverage and 40% report paying 0-20% of family coverage.[56]

Research is needed to determine the make up of the employees who decline coverage, for what reasons and their potential responsiveness to a premium subsidy. Two recent studies shed some light on the take up problem. Howard Greenwald et al, report that the dominant reasons for lack of coverage for working Latinos are the cost of coverage and the lack of an employer offer; however the study found 14% of respondents who do not "value" coverage; many were workers who had never had coverage.[57] Jill Yegian investigated the willingness of uninsured individuals with incomes over 200% of FPL to purchase individual coverage; she identified a somewhat larger subset of 30% of the non-poor uninsured who did not value coverage.[58] Many in the provider community refer to this group as the young immortals (most typically young males) who do not use health services or value coverage until an emergency event occurs.

In summary, affordability for low wage employees is a problem for both the insured and uninsured, but take up has not yet emerged as the most serious problem. The *value* that individual employees place on health coverage may be connected to affordability, the individual's demographic profile and the design of employee contributions. Employee premium contributions are typically based on a percentage share of the employer's composite rate. This design of employee contributions cross subsidizes from young and healthy employees who have a low likelihood of using health services to older, often better paid employees with more significant assets -- who for these reasons may place a higher value on health coverage. We recommend that the employee share of premiums be based on a percentage of employee wages, rather than a percentage of employer premiums; this can be done in a cost neutral fashion. The following chart is an example of structuring employee premiums based on wages versus based on a percent of premium; for purposes of illustration we increased wages with age in a four employee firm.

STRUCTURING PREMIUM CONTRIBUTIONS BASED ON PERCENT OF WAGES OR PERCENT OF PREMIUMS

Average Monthly Salary	**Employee contribution (33% of average premium)**	**Employee contribution (2% of wages)**	**Employer contribution (67% of average premium)**	**Age rated Premium**	**Average premium**
$800	$40	($16)	$80	$90 (under age 30)	$120
$1600	$40	($32)	$80	$105 (over 30)	$120
$2400	$40	($48)	$80	$125 (over 40)	$120
$3200	$40	($64)	$80	$160 (over 50)	$120

B. Proposal

ITUP's proposal is to target low wage uninsured working families who must pay more than a designated percentage (e.g. 2-3%) of family income for employer sponsored family coverage. The challenges are to 1) design an effective tax credit to help the lower wage working family with an inordinate share of family income devoted to family coverage without inducing employers to reduce their contributions; 2) make the credit refundable and timed to the employee's monthly contributions; and 3) sufficiently target the credit so that it does not unduly subsidize those who need no subsidies. We investigated two alternatives: a refundable state tax credit and the Healthy Families purchasing credit.

The federal government has a refundable Earned Income Tax Credit (EITC) and a child care tax credit. California has a refundable child care tax credit. The federal EITC included a component to pay for health coverage, which was dropped, as it proved unworkable.[59] EITC is used by 2.4 million Californians; the average pay out is $1601 and the income limits are $10,380 for a single adult, $27,813 for one child and $31,152 for two or more children.[60] It was not workable to pay health premiums through the EITC in part because EITC is payable once a year, while employee's share of premiums are deducted monthly. It may be possible for California to "piggy back" a refundable health

insurance tax credit on top of the federal EITC, but it would not reach the employees when they need it -- in their monthly paychecks. There are several suggestions how to correct this timing problem. Some involve advancing part of the refundable credit monthly through the employee's tax withholding and the remainder at the end of the year when the household's family income and tax liability is reported.[61] EITC is based on family income, while payroll tax deductions are based on an individual employee's wages, which often are only a portion of household income.

Federal and state child care tax credits reach both low and higher income families, decreasing in value as family income increases and phasing out at $100,000 adjusted gross income. Could we model an employee health insurance credit similar to the child care tax credit? The differences between employees' child care costs and their share of health insurance premiums are substantial: child care costs at least four times as much; employees can not go to work without it, and few employers contribute.

To provide a monthly or quarterly, refundable tax credit for low income employees' share of employer health premiums in California would require the cooperation of EDD, the Franchise Tax Board, the employee and the employer. FTB receives the information on family incomes as individuals file their annual tax returns. EDD receives information on employee wages quarterly; there may be as much as a four months lag in compiling the tax information submitted (manually as opposed to electronically) by small employers.

To simplify the administration of the credit, the employee could self certify that they are eligible for the credit (as one does for number of dependents) and pay at a lower state tax withholding rate. Reconciliation to tax liability could be done at the end of the tax year. However payment of the refundable portion of the credit would then be postponed until the end of the taxable year. Would this reach very low earners? FTB reports that individual filers with incomes below $9811 and joint filers with incomes below $19,071 are exempt from state income tax, but many file end of the year tax returns to recover their tax refunds.

The credit is likely to exceed state income tax liability of low wage working families; thus a refundable tax credit is needed, which requires a General Fund appropriation. Refundable tax credits pose unique tax fraud challenges for the administering tax agencies as some unscrupulous individuals have created phony tax refund mills. Urban Institute reports that refundable tax credits are disproportionately not received by low wage Hispanic immigrant workers due to limited English speaking skills, low educational attainment and lack of familiarity with the rules and eligibility for tax refunds; this is the same population that is disproportionately uninsured.[62]

A Healthy Families purchasing credit administered by MRMIB better targets uninsured low wage families who cannot afford family coverage premiums, has a larger impact in increasing coverage for the uninsured and uses federal matching funds at a lower state cost than a refundable state tax credit. The Healthy Families legislation authorizes a purchasing credit to pay an employee's share of employer premiums.[63] MediCal's HIPP (Health Insurance Premium Payment) Program authorizes the Department of Health

Services to pay an employee's share of employer premiums. The Healthy Families program is limited to uninsured children and (if the waiver is approved) to their uninsured parents. Using the Healthy Families credit targets the funding to those who are offered coverage, but have not taken up the offer.

The purchasing credit and MediCal HIPP program must be cost effective -- i.e. not pay more for coverage than Healthy Families and MediCal would otherwise pay for coverage. It is almost always less costly to the state to use the credit as the employer pays a share of coverage, but many employer plans have fewer benefits and higher co-pays than the Healthy Families program does. It is critical to provide supplemental or wrap around benefits to equalize coverage of those using the credit with those otherwise using the program without the credit. Wrap around benefits are easy to administer for uncovered benefits using MediCal's fee for service program, but more difficult to administer for plans with higher copays and deductibles than Healthy Families.

The purchasing credit is less costly to the state than a refundable tax credit as Healthy Families has a 2/1 federal match while the refundable employee tax credit might be 100% state General Fund cost. The refundable tax credit helps both insured and uninsured families and is thus more equitable for all wage earners but less cost effective than the purchasing credit in increasing coverage of the uninsured.

There are concerns about crowd out and crowd in at the intersections of public coverage, public subsidies and employer contributions. Healthy Families reaches a small niche -- less than 2% of Californians -- and is not very likely to induce significant crowd out of employer sponsored coverage. Healthy Families' purchasing credit assists uninsured families to purchase employer offered coverage; this credit is more likely to prevent than to increase crowd out. There is a concern that employers in response to a refundable tax credit which reaches more than half of working families could increase employee shares of premium and thus substitute the state tax credit to employees for the employer's own contributions.

California has many mixed immigration status, low income uninsured families.[64] Healthy Families does not reach family members ineligible for federal and state public programs. A refundable tax credit would be the better of the two approaches at reaching immigrant families who are deterred by their immigration status from enrolling in public programs.

On balance we recommend implementation of the Healthy Families purchasing credit as the better of the two approaches to increase take up rates of employer offered coverage by uninsured employees.

REFUNDABLE TAX CREDIT/VOUCHERS FOR THE FLEX WORKFORCE (Appendix 3)

A. Research

The flex workforce may account for as much as 30% of workers and include nearly half of uninsured California workers.[65] The flex workforce includes part time, seasonal, contract, temporary workers and the self employed. Flex workers are as disparate as the day laborer, migrant worker, gardener, artist, entertainer and computer consultant; they have in common a low rate of employment based coverage and high rate of uninsurance. Flex workers are more disadvantaged than the rest of the workforce because there is typically no employer contribution. Only self employed flex workers receive any federal and state tax subsidy (100% tax deductibility for the self employed in 2003) if they purchase individual coverage. Recent research indicates that lack of coverage for a growing flex workforce is the key component in the past and projected future declines of employment based coverage.[66]

Flex workers who do have employment based coverage are often covered as a dependent of a full time, full year worker.[67] Since most flex workers are not covered through their own employer, the likelihood of crowd out or displacement of existing employer sponsored coverage for the employee is low.[68] The studies we reviewed found that only 12% of flex workers had employment based coverage through their own job; by contrast most full time, full year employees are offered coverage at work.[69] Coverage varies by the type of flex worker.[70]

- Self employed: 39% uninsured, 29% covered through a spouse's job, 25% with individual coverage and 4% with public coverage;
- Part timers: 36% uninsured, 37% covered through their spouses or their own job, 7% with individual coverage and 17% with public coverage; and
- Seasonal: 28% uninsured, 48% covered through their own or a spouse's job, 3% with individual coverage and 20% with public coverage;
- Temps: 53% uninsured;
- On call workers: 33% uninsured, and
- Full time workers 15-16% uninsured, 75% with employment based coverage, 3% with individual coverage and 3% with public coverage.[71]

Flex workers are typically much younger than the overall work force and thus less costly to insure. In 1995 among all the different types of flex workers, a very large percentage (estimates ranged from 31-42%) was between the ages of 16 to 24. Their tenures as flex workers are typically short.[72] As workers age, they are increasingly likely to spend longer periods working in the flex workforce.[73] 20% of workers aged 50 to 64 are employed in flexible work arrangements; demographic trends among the baby-boom generation indicate that an increasing number of 50-64 year olds may seek similar arrangements in the future.[74]

We include in the flex workforce, the 1.5 million self insured Californians, who are typically older, with higher incomes and greater assets, more males and more non-

Hispanic whites than the part time, seasonal and temporary workforces.[75] 51% of the self employed work in the services industry, and this ranges from doctors and accountants to home care workers; 10% are in agriculture, comprising over 25% of the agricultural workforce, The self employed comprise 10% of California's workers. Temp workers by contrast are mostly young workers and comprise 1-2% of the workforce.[76] Part timers are the largest and fastest growing component of uninsured flex workers.[77]

There are a number of efforts to cover flex workers throughout California and across the country. These include the efforts to cover home care workers, child care workers, public and academic flex workers, Silicon Valley temp workers, employees in the construction, high tech, artistic and entertainment industries.[78] Typically these efforts include both a new or revised purchasing structure such as a union, ERISA or association trust or a public purchasing entity and some form of public and/or employer subsidy. None that we have reviewed are self financed by the premiums of flex workers themselves other than Working Today, an association plan for free lancers based in New York. See Models for Flex Workers Coverage attached.

B. Proposal

Individual refundable tax credits could be an efficient way to fund coverage opportunities to workers who are unlikely to be covered through their own employment. Challenges in designing such subsidies include 1) timing, 2) size, 3) simplicity, 4) refundability, 5) targeting and 6) linkage to efficient group purchasing and/or a reformed individual market.

ITUP recommends refundable tax credits tied to the purchase of health coverage for low and moderate income persons who are not offered coverage through the workplace. This means that workers who are not offered employment based coverage (whether flex or not) can get the credit to purchase coverage.

ITUP's proposal is that the premium subsidy for the self employed be linked to quarterly estimated tax payments to the Franchise Tax Board and delivered as a refundable tax credit/voucher matched to an individual's quarterly premium payments to carriers. Franchise Tax Board points out that some of the self employed do not pay estimated taxes quarterly as their income flows are highly seasonal in nature, especially centered on the holiday season.

We recommend that the premium subsidy for flex and other uninsured employees be in the form of a voucher/refundable tax credit and tied to quarterly premium payments to health plans. FTB and EDD inform us that refundable tax credits have been subject to fraud by unscrupulous tax mills. The health voucher approach we suggest should reduce the opportunities for fraud.

Our recommendation is that the premium subsidy is made available for all low and middle wage workers *who are not offered coverage* at the workplace. We initially proposed limiting this subsidy to flex workers, but the definitional line drawing involved

(as to who qualifies for the subsidy and who does not) is complex and the results inequitable (e.g. an uninsured employee working 24 hours or less each might get the subsidy while those uninsured and working 25 hours might not qualify).

- Workers who are offered coverage by an employer, but do not take up offered coverage would be ineligible for this credit; they could be eligible for premium assistance through the Healthy Families purchasing credit discussed earlier.

B. Some employers offer coverage to some classes of workers but not to others: e.g. coverage is offered to store or restaurant managers, but not to other classes such as salespersons, waitresses, busboys or dishwashers, working less than 25 hours a week. Under our proposal, part time workers not offered coverage would qualify, but the full time managers who are offered coverage would not.

C. Some employers such as realtors may offer coverage to clerical office staff, but not to salespersons earning commissions. The sales staff could qualify for the credit, but the clerical office staff would not.

D. Thirty to ninety day waiting periods to begin coverage for new employees are not uncommon among employers. These distinctions exist now for many employers, and we do not propose to change them.

E. We are concerned that there may be incentives for personnel managers to game the subsidy by limiting their offers of coverage for example, to higher paid employee and longer tenured classifications. If this occurs, state and federal law need to be amended to deny favorable tax subsidies for employment based coverage to employers whose employee classification systems effectively exclude lower income workers.

F. Individual tax credits/vouchers will also be used to finance transitional coverage during job layoffs or for workers changing jobs.[79]

We propose that the voucher/refundable tax credit for flex employees be administered through a cooperative effort of FTB and EDD. FTB receives taxpayer information about family household income annually. EDD has up to date, employee specific wage information on a quarterly basis, but does not know the employee's household income. The uninsured worker would self certify their eligibility for the credit during any quarter of the tax year; the credit/voucher would begin in the ensuing quarter.[80] EDD and FTB would cross check and audit as necessary.

We want to avoid incentives for *offering* employers to drop coverage and shift their employees into the individual market and for insured employees to drop coverage to avail themselves of the premium subsidy. We recommend that the subsidy for low wage workers (under 200% of FPL) not offered coverage should approximate an employer's share of premium cost of basic coverage for small employers. We recommend $1200 for employees up to age 40, $2400 for employees up to age 55 and $3600 for employees between 55 and 65; these amounts would need to be adjusted for rising health premiums, possibly tied to the rate adjustments negotiated by the most efficient group purchasers.[81] The uninsured flex worker must pay at least 10% of the cost of individual coverage and 20% of the cost of family coverage. The employee who drops or declines employer offered coverage is not eligible for the credit.

We also wish to avoid incentives for families eligible for Healthy Families to seek the credit because the cost of the credit/voucher could be 100% state costs while Healthy Families is 67% federally reimbursed. Our proposed subsidies for larger family sizes are much lower as a percentage of premium. For family coverage, we are proposing $2,200 for employees up to age 40, $3200 for employees from age 40 up to age 55 and $4500 for employees from 55 to 64. Under the recent federal guidance letter on federal §1115 waivers, it may be possible to secure federal matching for vouchers for persons with incomes of less than 200% of FPL. [82]

HIPC/PacAdvantage Lowest Priced Plan Monthly Premiums in Los Angeles[83]

Age *Individual subsidy* *Family subsidy*	Employee only	Employee and spouse	Employee and children	Employee, spouse and children
Under 30 *$1200* *$2200*	$91	$210	$200	$294
30-39 *$1200* *$2200*	$106	$232	$207	$346
40-49 *$2400* *$3200*	$122	$266	$231	$367
50-54 *$2400* *$3200*	$167	$335	$249	$408
55-59 *$3600* *$4500*	$205	$400	$288	$449
60-64 *$3600* *$4500*	$255	$500	$342	$607

The value of the individual tax credit/voucher should phase down beginning at 200% of FPL and phase out entirely at $35,000 (adjusted annual gross income) for an individual and $70,000 for families. For individuals, this is about 400% of the federal poverty level and somewhat higher than the state's median adjusted gross income of $29,000 for individuals. For families this is about 400% of the federal poverty level for a family of four and significantly higher than the state median adjusted gross income of $45,000 for households. [84]

As discussed previously, our proposed credit/voucher reaches both low and middle income tax payers who have no employer contribution and little if any tax subsidy equivalent to the tax advantages of those covered through their employer. This proposal achieves tax equity. Some may say that low income earners pay little state income taxes; however they do pay sales taxes, tobacco taxes, utility taxes, and property taxes. The reported percentages of the income devoted to state taxes are: 12% of income for the lowest 20% of households, 9.2% for the second 20% of wage earners and 8.5% of income for the middle 20% of households. [85]

As there are several federal proposals and federal budget authority for a tax credit for individuals, California would need to coordinate its approach with the approach if any eventually approved in Congress.[86] A typical federal proposal is $1000 for an individual and $2000 for a family. These amounts come close to California small employer premiums for young workers, but do not make coverage affordable for older workers.[87] Our proposal makes coverage affordable for flex workers of all ages.

The individual market has none of the intra workplace premium subsidies of the employer market. The individual market's premium structure may be more attractive to young, healthy and high paid workers than the employment based system. For lower income young workers or for higher income older or sicker workers, individual coverage is a market of last resort, and its premium structure is a disincentive to enrollment. An estimated 5% of Californians (1.5 million individuals) now receive coverage through the individual market. The credit/voucher we propose will attract a new mix of young and older low and middle income uninsured workers and could add as many as 1.5 million new enrollees. We expect that most low wage working families will enroll in Healthy Families, which offers broader benefits and lower premiums. Low and middle income flex workers and middle income flex worker families will be attracted into the individual market by the subsidy we propose.

The individual market is now dominated by Blue Cross, Blue Shield, Health Net and Kaiser Permanente -- large carriers with long experience in this market. The premium subsidies we propose are likely to attract new market competitors, and the structure of the premium subsidies should increase price competition and broker marketing efforts in the individual market.

Individual purchasing can result in adverse selection as individuals may buy coverage only when they need it. Carrier underwriting policies do exclude coverage for individuals identified as high risk. California's individual market has not been reformed (as its small employer market has been) and requires market reforms that assure access to coverage, deter adverse selection and restrain underwriting abuses in order to make our proposed approach viable. It would be unacceptable to subsidize entry into this market and permit carriers to continue to exclude high risk individuals. We propose the following individual market reforms:

- Guaranteed issue and renewal with a 12 month pre-existing condition exclusion for those without continuity of coverage (as already defined under California law)
- Age and geography rating
- A 25% cap on initial health status rating.[88]

The market reforms must include transparent pricing so that individuals purchasing coverage will have access to clear and consistent price information, comparable to other major purchases such as a car. Other states regulating the individual market made mistakes which California needs to avoid: such as a pure community rate which led young healthy individuals to drop coverage and an escape hatch for association coverage which allowed some carriers to cream the individual market's good risks with association coverage and leave the bad risks for a few remaining carriers.

Individual purchasing is not as efficient as group purchasing; we propose combining the tax subsidies with better access to group purchasing opportunities for flex workers through associations, Taft Hartley and ERISA trusts, purchasing pools and large employers and a reformed individual market. There is no public purchasing pool comparable to the HIPC/PacAdvantage for individual purchasers; one needs to be funded and established. Employer associations, union trusts and self insured large employers who already purchase coverage should be permitted, indeed encouraged to serve as the purchasing/bargaining agent for those flex workers with vouchers. Flex workers who would wish to use their vouchers to purchase coverage through Healthy Families or MediCal should be allowed to purchase coverage at a transparent and actuarially sustainable amount.

§1115 WAIVER TO COVER INDIGENT ADULTS WITHOUT MINOR CHILDREN

(Appendix 4)

A. Research

California covered indigent adults (MIAs) through MediCal with no federal matching funds until 1983. MediCal coverage was terminated because the state was in recession and no federal matching funds were available for their care. State funding was transferred to the counties, which took on the responsibility for operating health systems for indigent adults. County programs provide care for a mix of chronically ill adults and individual medical emergency episodes for healthy adults.

In California there are about 1.2 million indigent adults with incomes below the federal poverty line and another 2 million with incomes between 100% and 250% of FPL.[89] Thirty eight percent are parents with children who can be covered under MediCal or under the state's §1115 waiver to cover the parents of Healthy Families children. Over 60% are adults, who are not parents of minor children and thus not eligible for either the MediCal or Healthy Families absent a federal Medicaid §1115 waiver to cover *unlinked adults.*[90] 75% of uninsured adults are citizens or legal permanent residents and thus are not disqualified for MediCal by immigration status.[91] Persons who have not yet received full, legal permanent resident status from the Immigration and Naturalization Service can be eligible for limited scope MediCal benefits (emergency care only).

We estimate that there are 730,000 uninsured unlinked adults below 100% of FPL and 1.2 million uninsured unlinked adults between 100% and 250% of FPL. Under an approved §1115 Medicaid waiver, citizens and legal permanent residents (75%) would be eligible for full scope benefits, and undocumented and others without legal permanent residency status (25%) would be eligible for limited scope benefits.

Arizona, Oregon, Massachusetts, Tennessee and New York already have federal 1115 waivers to cover indigent adults through Medicaid managed care. Oregon and Tennessee were particularly successful at reducing their numbers of uninsured through waivers.[92]

B. Proposal

We propose that California seek an §1115 waiver to cover indigent adults using federal matching funds. The waiver would cover those adults with incomes below poverty level (730,000) through MediCal and cover adults with incomes between 100 and 200% of FPL (900,000) through Healthy Families. An 1115 waiver would allow California to access federal matching funds for emergency services to adult immigrants not otherwise eligible for MediCal (roughly 25% of the above figures), thus helping California's financially troubled trauma and emergency services.

To simplify this discussion, we use the figures of 100% of Federal Poverty Level (FPL) for MediCal and 200% of FPL for Healthy Families. We recognize that many would

prefer the threshold eligibility of 133% of FPL for MediCal eligibility and 133-250% of FPL for Healthy Families, but the data is more readily available to explain these ideas by using the figures of 100 and 200% of FPL respectively. The recent federal guidelines put a severe burden of proof on a state seeking to expand public coverage above 200% of FPL and make it easier for a state to set the bright line between MediCal and Healthy Families eligibility at 133% of FPL rather than 100% of FPL.[93]

California counties are funded through realignment, Prop 99 and a county match to care for indigent adults (MIAs). They report spending at least $1.5 billion on care for 1.5 million indigent uninsured.[94] These funds could be doubled with a federal Medicaid match or tripled with a Healthy Families style match, but only if the state and counties are willing to use the money to expand coverage. The National Governor's Association is on record in support of expanding Medicaid to cover indigent adults and a bipartisan group of senators agreed on $28 billion budget augmentation for states to expand their public programs for the uninsured.

Counties have developed very different local delivery systems and funding, some of which are excellent models and building blocks to cover the uninsured.[95] We propose that California combine its funding streams for indigent health care, seek a federal waiver to deliver managed care to the MIAs and allow sufficient local flexibility to induce pioneering counties' support, cooperation and participation.

Our proposal divides California counties into three groups: CMSP (County Medical Services Program for small counties), payor and provider MISP (Medically Indigent Services Program) counties.

County Medical Services Program for 34 Small Counties

County Medical Services Program pays for care to indigent adults in 34 mostly rural counties with small populations. CMSP counties operate a fee for service system of care for the uninsured indigent through the state Department of Health Services. It is similar to MediCal, but with no federal matching funds and fewer benefits. CMSP program eligibility could be readily expanded and needed services added with the infusion of federal matching funds.

CMSP counties spent $176.4 million in FY 2000 on care for 63,000 users of services (a cost per user of $2800).[96] Of that total, 54% was spent on hospital inpatient services, 14% on hospital outpatient care, 19% on pharmacy and 13% on medical care (this includes both community clinic services and physician visits).[97] The program appears to provide comparatively little funding for out of hospital care to uninsured indigent adults. In a recent ITUP study of 10 Northern California counties, we found that CMSP paid for approximately half of hospital care to the uninsured; while it paid for only about 15% of community clinics uninsured visits.[98] Clinics' uninsured visits were paid in part through CMSP, EAPC, other state programs, other county programs and the patients themselves.[99]

We estimate that reported users of CMSP services are 80% of uninsured, unlinked indigent adults below the federal poverty line in the 34 CMSP counties and 37% of uninsured, unlinked indigent adults below 200% of FPL.[100] In using the term uninsured, unlinked indigent adults we refer to individuals who could not qualify for either MediCal or Healthy Families due to linkage -- a term which includes families with children, the disabled and aged and excludes single individuals and couples without minor children.

For 1998-9, CMSP was funded as follows: realignment $124 million, state general fund $20 million, Proposition 99 $10 million, and county funds $5.5 million.[101] The addition of an equal amount of federal matching funds would allow the program to expand eligibility, enrollment and access to medical services quite dramatically. At recent workgroups we conducted in Redding and Eureka, California, the participants pointed to the deterrent effect of MediCal/CMSP assets test and the difficulties they experience in enrolling eligible patients into the MediCal and CMSP programs in rural areas due to the inaccessibility of county social services offices as the two largest reasons for low enrollment in public programs.

Solano County is planning to incorporate its program for the medically indigent adults into its MediCal managed care plan beginning in January 2002. In a recent study we completed of 10 Northern California small counties, the impact of MediCal managed care in reducing inappropriate emergency room usage in Solano was apparent and notable.[102]

Medically Indigent Services Program (MISP) Payor Counties

Payor counties such as Orange and San Diego, Sacramento, Santa Barbara and Fresno pay private providers for their care to medically indigent adults. Their care to the uninsured is financed through realignment, Prop 99 and county matching funds. These counties have no access to federal matching funds for their MISP programs.

Individual private hospitals in these counties receive significant DSH (Disproportionate Share Hospital) and SB 1255 funding to defray their costs of caring for the uninsured.[103] University of California hospitals in Orange, San Diego and Sacramento contribute the required state/local match. By contrast, in the 10 small Northern California counties we studied, none of the hospitals reported receiving any DSH funding.[104]

Eligibility rules and the eligibility process for the payor county programs are roughly the same as for MediCal. Covered services are somewhat less. Provider payments are typically a modified fee for service within a capped allocation.[105]

We propose that the payor county programs be incorporated into managed care through the state's MediCal program.[106] Setting capitated rates will be challenging because of the actuarial differences between the population using county systems and the larger and healthier population of poor persons who are eligible but not using county health services, the uncertainties of enrollment in an expanded, state administered program and the lack of good statewide data on this population's use of health care.[107]

- In San Diego County for example, there are 541,000 uninsured -- about 19% of the county's population under age 65. San Diego County covered 22,000 indigent adults at a cost of $40 million in the year 1997-8 through its CMS program. We estimate there are 54,000 uninsured unlinked adults in the county with incomes below 100% of FPL; about 40% of this eligible population use the county program.

- The county reports spending 49% of its CMS budget on inpatient services, 37% for specialty care and 12% on primary care clinics.
- The county's CMS program pays for 22,000 (407 bed days per 1000 uninsured unlinked adult with incomes below 100% of FPL) inpatient days and 19,000 (351 visits per 1000) emergency room visits and 90,000 medical visits (1.6 visits per uninsured unlinked adult with incomes below 100% of FPL).[108]

- In Orange County for example, there are 667,000 uninsured -- about 23% of the county's population under age 65. Orange County covered 26,000 indigent adults at a cost of $52 million in the year 1998-9 through its MSI program. We estimate there are 67,000 uninsured unlinked adults in the county with incomes below 100% of FPL; about 40% of this eligible population use the county's MSI program.

- The county spends 74% of its MSI budget on hospital services, 20% for specialty care and 3% on primary care clinics.
1. The county MSI program pays for 39,000 inpatient days (582 bed days per 1000 uninsured unlinked adults with incomes below 100% of FPL) and 16,000 emergency room visits (239 visits per 1000) and 90,000 medical visits (1.3 visits per unlinked, uninsured county indigent adult).[109]

Provider networks in counties such as San Diego and Fresno is quite restricted and would need to be expanded.[110] In San Diego, primary care is reimbursed only in community clinics, and clinics are reimbursed for only 1 in 8 uninsured visits through the CMS program;[111] private physicians would need to be added to the mix. In Fresno, the county's indigent program is concentrated in a private hospital, the Fresno Community/University Medical Center, and the network would need to be expanded.

Selected payment rates would need to be increased to MediCal levels. In San Diego and Orange counties, private hospitals report to OSHPD that their inpatient reimbursements through the county program for the medically indigent are approximately the same as under the MediCal program; Orange hospitals, however, report their outpatient reimbursement under the county program is half of their reimbursement under the MediCal program. Fresno private hospitals report their county program payments per inpatient day and per outpatient visit are about half of the MediCal program. Sacramento private hospitals report their county program payments per inpatient day and per outpatient visit are about 10% less than MediCal program payments. [112]

Financing of county health care in payor counties is a mix of realignment, Prop 99 and county General funds:

2. For example in San Diego County in 1998-9, county health was financed by $74 million in realignment, $8 million from Prop 99 and $26 million in county General Funds.[113]
3. In Orange in 1998-9, county health was financed by $69 million in realignment, $8 million from Prop 99 and $28 million in county General Funds.[114]
4. County health departments provide more health services than care to uninsured adults; for example, they provide public health services. Less than half of available county health revenues in San Diego and Orange Counties are devoted to their county programs for the uninsured indigent adults.

The chronically ill in particular would benefit from the introduction of a managed care delivery system, by improving their access to an organized delivery system of primary and specialty care services.[115] The biggest service deficit in payor counties' health programs for uninsured adults is the lack of access to primary and outpatient care.[116] Access to primary care would need to be greatly expanded to make a managed care delivery system work in these counties.

Each of these counties already has a managed care system in place for MediCal families, and Orange and Santa Barbara County have a managed care system in place for the entire MediCal population. The addition of low income adults would be easiest for the health plans in Orange, Santa Barbara and San Diego counties, but would not be difficult for the commercial managed care plans in Fresno or Sacramento.[117]

Orange County has seriously considered merging its MSI (Medical Services to Indigents) program for uninsured adults into CalOptima, its MediCal managed care system; health officials in Orange conducted extensive studies, but concluded the MSI program's funding was insufficient. At ITUP workgroups, Santa Barbara and San Mateo County health officials have made similar observations, but without the detailed study undertaken in Orange. The addition of federal matching would double available funding and meet the funding needs projected by CalOptima in Orange County.[118]

Transition to managed care would be manageable in payor counties with the addition of federal matching funds, which doubles total program funding. Program income eligibility could be expanded; services and selected provider rates could be increased with the availability of federal matching funds.

Medically Indigent Services Program (MISP) Provider Counties

"Provider" counties such as Los Angeles, San Bernardino, Santa Clara, Kern and San Francisco provide care to the medically indigent adults through county hospitals and clinics.[119] Provider counties' care to the uninsured is financed through realignment, Prop 99, county matching funds, and federal funding though the DSH and SB 1255 programs.

Provider counties' eligibility levels are typically broader than the MediCal program, the CMSP counties and the payor counties. In Alameda and Santa Clara Counties, indigent uninsured adults are eligible for care with incomes up to 200% of FPL; those with incomes between 100 and 200% of FPL are expected to pay on a sliding fee scale basis. In Los Angeles County, sliding fee scale contributions are expected for those with incomes over 133% of FPL. Provider counties do not typically exclude uninsured patients based on age, immigration status or categorical linkage to MediCal and Healthy Families as the payor and small CMSP counties do.[120]

Provider counties do not use a MediCal or Healthy Families style enrollment process, but typically assess patient eligibility on an encounter basis. In Los Angeles, a patient's eligibility is assessed on admission or at the first visit, then re-assessed monthly for inpatient and semi-annually for outpatient care. In San Francisco, eligibility is reassessed monthly or on each visit. In Alameda County eligibility is redetermined annually.[121]

Provider counties rely on a shifting mix of federal MediCal matching through DSH (SB 855) and SB 1255 programs, state realignment and Prop 99 funding and county General Funds to support their care to the uninsured. The respective contributions are constantly shifting with recent declines in SB 855 and Prop 99 and recent increases in realignment and SB 1255 funding. Counties use only a portion of their health revenues for care to the uninsured; they also provide public health services and care to many MediCal patients. Unlike MISP payor counties, provider counties have access to federal matching funds for hospital based care to the uninsured through the DSH and SB 1255 programs.

- Alameda County health was financed in 1998-9 in part with $48 million from realignment, $7 million from Prop 99, $40 million from DSH (SB 855), $12 million from SB 1255 and $48 million from county General Funds. In Alameda in 1998-9, $69 million was budgeted for care to the uninsured.
- Santa Clara County health was financed in 1998-9 in part by $42 million from realignment, $8 million from Prop 99, $43 million from DSH, $12 million from SB 1255 and $37 million in county General Funds. Santa Clara County spent $75 million on care to the uninsured in 1997-8.
- Los Angeles County health was financed in 1998-9 in part by $395 million from realignment, $66 million from Prop 99, $237 million from DSH, $172 million from SB 1255, $114 million from the county's §1115 waiver and $160 million in county General Funds. Los Angeles County spent $772 million on care to the uninsured in 1997-8.[122]

Counties' federal funds through DSH and SB 1255 cannot be used to match other federal funds in meeting the matching requirements for Medicaid and Healthy Families. However county realignment, Prop 99 and county General Fund can be used as local match in the federal MediCal or Healthy Families programs. Some counties already use a portion of these funds as the match for DSH, and SB 1255 and more information needs to be gathered on the extent of matching opportunities in provider counties.

The financial status of county hospitals in provider counties is heavily dependent on their success in attracting and retaining MediCal eligible patients within the county system. For example in Los Angeles County with the state's largest and highest percentages of uninsured, the county hospitals' inpatient ratios are roughly 1/3 uninsured, and over 55% MediCal.[123] Many uninsured patients admitted to the county hospital eventually qualify for MediCal due to the efforts of county eligibility staff. Some county hospitals are experiencing declining MediCal participation due to a number of factors including increasing competition from private hospitals and declines in local MediCal enrollment.

Some Local Initiatives operating MediCal managed care plans have been extraordinarily successful. They have strengthened local safety net providers, improved the delivery system for MediCal eligibles, created innovative expansions of coverage and succeeded in the head to head competition for Healthy Families enrollment.[124] Others have been markedly less successful in these roles.

Delivery systems in provider counties are for the most part based in the county hospital for both historic and financial reasons associated with medical education and state and federal financing rules. The relative emphasis each county places on hospital based care and primary care outside hospital settings is very different.

- In Los Angeles, 85% of spending occurs in the county hospitals; the mix is 53% inpatient, 37% outpatient, and 8% emergency. 3% is spent for primary care through community clinics and other private partners.
- In Alameda, the mix is 35% inpatient, 55% outpatient, and 8% emergency. 10% is spent for primary care through community clinics.
- In Santa Clara, 82% of spending occurs in the county hospital; the mix is 35% inpatient, 49% outpatient, and 14% emergency. 3% is spent for primary care through community clinics.
- In San Francisco, the mix is 50% inpatient, 33% outpatient, and 14% emergency. 0.2% is spent for primary care through community clinics.[125]

Private hospitals and doctors are not reimbursed by provider counties for their care to the indigent uninsured, except to a limited degree through Prop 99, SB 12 and DSH.[126] A study in Los Angeles County noted that less than a third of net DSH funds were used for care to the uninsured in private hospitals and over two thirds in public hospitals.[127]

Contra Costa County is the only provider county which uses its public, managed care delivery system for its indigent adults. It reported that managed care enrollment by its indigent adults is quite low and its cost per user is very high: $480 per member per month or $5760 annually.[128] Several provider counties, including Alameda, Los Angeles and San Francisco have considered merging the MediCal and uninsured into a single managed care delivery system, county wide. Obstacles to such plans include competing interests of local providers, and the challenges of consolidating funding streams and programs.

Provider counties report their unduplicated users and expenditures to the state of California. While the accuracy of the county count of unduplicated users is less than 100%, the reported annual cost per unduplicated users and the reported participation of the county indigent uninsured in county health programs is as follows:

Provider Counties Eligibles, Users and Spending [129]

County	Uninsured	Unlinked uninsured adults below 200% of FPL	County reported unduplicated users	Participation rate	County reported uninsured spending	Spending per unduplicated user
Alameda	200,000	48,000	51,000	100%	$69 million	$1350
Los Angeles	2.6 million	624,000	797,000	127%	$772 million	$970
Santa Clara	258,000	62,000	60,000	100%	$76 million	$1270

This may indicate that provider counties are doing an excellent job of reaching the uninsured -- i.e. unlinked, uninsured adults are participating in the provider counties' programs at a much higher rate than in the payor or CMSP counties -- or it could be distorted by inaccuracies in the count of unduplicated users. Another comparison is to look at bed days, emergency room visits and outpatient visits for the target adult population, which avoids the uncertain accuracy of the county report of unduplicated users. The use of hospital and emergency room care in the provider counties equals or exceeds that of commercially insured populations while use of primary and outpatient services is somewhat less than the commercially insured.

Provider Counties: Eligibles, Days and Emergency and Outpatient Visits [130]

County	Uninsured	Unlinked uninsured adults below 200% of FPL (eligibles)	Hospital days and days per 1000 unlinked uninsured adults below 200% of FPL	Emergency room visits and visits per 1000	Outpatient visits and visits per uninsured adult below 200% of FPL	Spending per unlinked uninsured adult below 200% of FPL
Alameda	200,000	48,000	9,000 (187 per 1000)	15,000 (312 per 1000)	165,000 (3.4 per eligible)	$1440
Los Angeles	2.6 million	624,000	250,000 (400 per 1000)	254,000 (407 per 1000)	1,252,000 (2 per eligible)	$1240
Santa Clara	258,000	62,000	14,000 (225 per 1000)	28,000 (451 per 1000)	181,000 (2.9 per eligible)	$1225

For provider counties, instituting MediCal managed care coverage for the MIAs poses several challenges: competition with private providers, shifting from episodic to managed care and enrollment of their current patient populations in MediCal coverage.

- In some California counties, there is already strong competition between private and public hospitals over care to MediCal patients, allocation of federal DSH funding, funding of indigent care and even the renovation and rebuilding of public hospitals. Moving the uninsured into managed care will open heretofore closed county programs to contracting private providers. This competition will create conflict among competing local provider interests requiring resolution by managed care plans.
- Care and funding for indigent adults has been heavily concentrated within hospital settings in some provider counties. Moving to a more balanced delivery setting may be perceived as a threat to hospital based jobs, funding, medical education and vested decision making authority.
- Safety net providers report difficulties actually enrolling their eligible patient populations in programs such as MediCal and Healthy Families. To the extent that counties' funding is reduced and their patient populations do not in fact enroll; they are left with less funding to serve the same patient loads -- an untenable result.
- Provider counties treat working uninsured immigrant populations some of whom would not be eligible for full scope MediCal managed care services under a waiver.

To resolve these important challenges, we suggest the following options:

- Repeal counties' §17000 obligations for health care; they are outdated and this responsibility appropriately resides at the state and federal levels who already provide the bulk of funding for county health;
- Limit counties' financial obligations to a base of their three year average expenditures on the uninsured plus a factor for actual revenue growth;
- Place health plans at risk to control price and utilization and put state rather than county government at risk for the growth in the uninsured population;
- Have the funds follow the patients, i.e. county funds are not transferred until patients actually enroll;
- Give provider counties a "breathing room" option during a two year transition period to use their Local Initiatives as the dominant managed care option for indigent adults;
- As a part of the waiver, seek federal authority for more County Organized Health Systems -- which allow for a comprehensive, local negotiated managed care system;
- Leave an adequate residuum of better allocated safety net funding, and
- Give pioneering counties the option to fold in local DSH, SB 1255, SB 12 and EAPC funding, and implement COHS plans to enroll more of their local uninsured patients.

Important benefits include: increased federal funding for emergency, trauma and primary care, better access to care and a significantly improved delivery system. This approach could also help Los Angeles County's public and private providers avoid the threatened financial meltdown as its waiver phases out.

- This approach increases emergency and trauma funding by accessing a federal match for unlinked adults and for immigrants not now eligible for MediCal or Healthy Families
- It replaces hospital emergency room centered system with a managed care system, beginning with primary care and linking access to specialty and hospital care.

- It gives the patient choices of provider and links the community and county providers together in a system of care responsible to the patient.
- It replaces Los Angeles County's bail out waiver with its declining levels of federal support with a sustainable waiver, financing an organized system of care for the county indigent.

California has substantial federal, state, and county financial commitments to "safety net" providers and barriers that impede efforts to develop health coverage and systems of care for the indigent:

- Multiple, disconnected programs and funding streams dedicated to the care of the indigent uninsured.[131]
- Funding streams, financial incentives and delivery systems for care to the indigent uninsured that are at odds with the managed care approaches for the insured commercial, MediCal and Healthy Families populations.[132]

Under ITUP's proposal, the state would connect state and county programs and funding streams for the uninsured with a federal Medicaid/Healthy Families match. For example, we would merge stand alone programs into coverage for the uninsured; this would include programs for adults and families such as GHPP, Family PACT, AIM, MediCal share of cost, MediCal pregnancy only coverage, Breast Cancer, Prostate Cancer, AIDS, and Tuberculosis Treatment Funds as well as CHDP screening and treatment and CCS. Safety net programs dedicated to particular providers such as emergency room doctors, rural and community clinics, county hospitals, and trauma centers would be merged to buy coverage for the indigent uninsured. Interested counties would have the option to organize coherent, local, managed care delivery systems for the uninsured, and the state would contract with managed care entities and/or operate a fee for service system in the remaining counties. Federal matching would allow for expansion of eligibility, services and payments for primary, emergency and trauma care. MediCal managed care would be able to improve local delivery systems especially for chronically ill low income adults.

We propose to draw a bright line between MediCal and Healthy Families programs so that all individuals and family members with incomes above that line are eligible for Healthy Families and all individuals and family members with incomes below that line are eligible for MediCal. We suggest that the line should be drawn at either 133% or 100% of FPL.[133] We recommend that the MediCal asset test be eliminated and all the MediCal subcategories of eligibility be consolidated, thus vastly simplifying the MediCal application and eligibility determination process. We recommend that all net available income is counted with a single deduction for child care and for work expenses. Some persons with MediCal eligibility will be shifted into Healthy Families as the subcategories such as MediCal share of cost or pregnancy only coverage are eliminated. We propose that eligibility once established is good for one year. If the annual redetermination process shows an increase or decrease in income, moving the individual's eligibility between MediCal and Healthy Families, that shift would be done administratively, rather than requiring the person to reapply for a new program. These changes will assure continuity of care and require a §1115 waiver.

Medi-Cal 12-Month Retention for Major Aid Categories, 1994-1997[134]

Starting Year	All	SSI/SSP	AFDC-Cash	M/C only Families	M/C Only A/B/D	Share of Cost	OBRA
1994	75%	90%	78%	35%	64%	8%	40%
1995	73%	90%	75%	36%	70%	9%	40%
1996	60%	86%	66%	24%	54%	3%	26%
1997	72%	91%	71%	37%	65%	11%	

Source: DHS Annual Reports.

The safety net would be funded albeit at a reduced level, reflecting the enrollment of many of the uninsured in coverage and the shift of their financing. We suggest restructuring the residual safety net funding so that is linked to the disproportionate financial burdens of caring for genuinely uninsured patients with no other payment source. Current safety net funding is not linked to care of uninsured patients with no other source of payment; it has become a series of intricate and impenetrable institutional subsidies, reflecting trade-offs negotiated at county and state levels between and among provider associations and state and county governments. Funding is narrowly channeled (silo funding): this amount is for emergency room doctors, this portion is for public and that portion for private DSH hospitals, this pot for community clinics, and that pot for specialists. We suggest that safety net funding be linked to systems of care for the uninsured and be proportionate to their care of the residual uninsured.

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[1] Compared to the top ranked state of Wisconsin, California's employment based coverage was 20 points lower. Urban Institute, Assessing the New Federalism Series (Washington DC, 1997-2000)

[2] Brown et al, The State of Health Insurance 2000, Recent Trends, Future Prospects (UCLA Center for Health Policy Research, 2001). Paul Fronstin of EBRI in a report commissioned by the California HealthCare Foundation finds that the distinguishing feature accounting for California's low rate of employment based coverage is lack of employer sponsored coverage for the state's large immigrant workforce. Fronstin, Health Insurance Coverage and the Job Market in California, EBRI Special Report 36 (Employee Benefits Research Institute, 2000)

[3] See Custer et al., Why We Should Keep the Employment Based Health System, Health Affairs (Nov.Dec.. 1999) p. 115

[4] See Wulsin, California at the Crossroads: Choices for Health Care Reform (Center for Government Studies, Los Angeles, 1994); J. Meyer and E. Wicks, A Federal Tax Credit to Encourage Employers to Offer Health Coverage (Economic and Social Research Institute, Dec. 2000) at www.cmwf.org and Pauly and Herring, Expanding Coverage via Tax Credits: Trade Offs and Outcomes, Health Affairs (Jan/Feb. 2001).

[5] It is poorly designed to cover low wage workforces because the tax subsidy is low and the marginal cost of compensation is very high. It is poorly designed for young workforces because employee premium contributions are typically structured to cross subsidize coverage for older workers from young workers. Ibid.

[6] Brown, The State of Health Insurance 2000

[7] Federal Medicaid law includes restrictions on coverage to adults without minor children, new (i.e. those immigrating since 8/26/96) and undocumented immigrants.

[8] See e.g. L. Blumberg and L. Nichols, The Working Uninsured In California (Urban Institute and Kaiser Family Foundation, 2001); Levitt and Gabel, 2000 California Employer Health Benefits Survey (Kaiser

Family Foundation and Health Research and Educational Survey, 2001) and Brown et al, The State of Health Insurance 2000, Recent Trends, Future Prospects all showing high take up rates for employment based coverage in California, even for very low wage workers.

[9] Brown et al, The State of Health Insurance 2000

[10] Public programs can be a poor fit for immigrants due the "fear" factor, the exclusion of the not-yet-documented in mixed status families and the difficulty in adjusting MediCal and county health program eligibility policies to coverage for workers. Professor David Hayes Bautista of UCLA points to the low rate of use of health services by immigrants, even when they are covered and the need to develop coverage, care models and prices appropriate for the immigrant community. Western Growers' Association has developed low cost plans and cross border coverage for some migrant farmworkers. See ITUP Conference Binders 1999-2001 Tabs on Employment Based Coverage and Immigrant Coverage available at www.work-and-health.org/itup.

[11] California Employment Development Department, Labor Market Information, Covered Employment and Wages - Major Industries 1999 at www.calmis.ca.gov.

[12] These estimates based on our review of the Health Insurance Policy Program series 1996-2000 by Brown and Schauffler, Levitt and Gabel, California Employer Health Insurance Benefits 2000, Wm. Mercer Inc. Employer Sponsored Health Insurance: A Survey of Small Employers in California (CA Health care Foundation, Aug. 1999) and Fronstin, Health Insurance Coverage and the Job Market in California. The estimates of coverage by industry vary significantly from study to study by the different authors and in the Brown Schauffler report from annual report to annual report.

[13] For example there was little difference in average annual pay between residential and general building contractors, or between carpentry, painting, plastering and masonry; heavy construction and electrical work had significantly higher pay. See Labor Market Information, Covered Employment and Wages - Construction Industry 1999 at www.calmis.ca.gov.

[14] Ibid. See discussion in ITUP Flex Working Group on the Flex Workforce.

[15] See Covered Employment and Wages - Services Industry 1999 at www.calmis.ca.gov.

[16] See n. 12.

[17] See California Employment Development Department, Labor Market Division, 2001 Average Weekly Hours, Average Hourly Earnings and Average Weekly Earnings at www.calmis.ca.gov

[18] See California Employment Development Department, Labor Market Information Division, 1999 Number of UI Insured Employees by Size of Reporting Unit at www.calmis.ca.gov

[19] Phone interview with Employment Development Department on 9/14/01.

[20] See California Employment Development Department, Labor Market Information Division, Hourly Pay and the Minimum Wage (March 2001) at www.calmis.ca.gov

[21] Brown et al, The State of Health Insurance 2000

[22] Phone interview with Employment Development Department

[23] US Dept. of Health and Human Services, 2001 Poverty Guidelines at www.aspe.hhh.gov/poverty.

[24] See Brown et al, The State of Health Insurance 2000 and Levitt et al, 2000 California Employer Health Benefits Survey

[25] See Wm. Custer, The Changing Sources of Health Insurance (Center for Risk Management and Health Insurance Research, Dec. 2000), and Acs and Blumberg, How A Changing Workforce Affects Employer Sponsored Insurance, Health Affairs (Jan/Feb. 2001) projecting a long term decline in employment based coverage.

[26] Brown et al, The State of Health Insurance 2000, Recent Trends, Future Prospects; Levitt and Gabel, Employer Health Benefits 2000 and California Health Benefits Survey 2000.

[27] The HIPC had initial success in negotiating premium reductions, but has not grown to a size where it is able to consistently exercise strong bargaining power. There is some belief that its benefits package is too broad to be attractive to small businesses on the verge of purchasing coverage. See Long and Marquis, Have Small Health Insurance Purchasing Alliances Increased Coverage, Health Affairs (Jan/Feb. 2001).

[28] California Employment Development Department, Labor Market Information Division, Reporting Units, UI Insured Employment and Payroll by Size of Reporting Units (1999) at www.calmis.ca.gov

[29] Levitt and Gabel, Employer Health Benefits 2000 (Kaiser Family Foundation, 2000).

[30] See Brown and Schauffler, The State of Health Insurance, 1999 (Health Insurance Policy Program, 2000) and Levitt and Gabel, California Health Benefits Survey 2000

[31] See Sharon Silow-Carrol, State and Local Initiatives to Enhance Health Coverage of the Working Uninsured (Commonwealth Fund, Nov. 2000) and R. Kronick and D. Strom, Survey of FOCUS Program< Report of Findings (2001) (unpublished manuscript)
[32] Silow-Carrol, State and Local Initiatives to Enhance Health Coverage of the Working Uninsured
[33] Ibid.
[34] Ibid.
[35] Resource Group, Report of Small Business Employer and Employee Health Insurance Coverage, 1999
[36] See e.g. AB 32 (Richman and Figueroa), AB 39 (Thomson and Campbell), AB 482 (Cedillo) and AB 694 (Corbett) offering premium subsidies from 20 to 50%.
[37] See Long and Marquis, Have Small Health Insurance Purchasing Alliances Increased Coverage, Health Affairs (Jan/Feb. 2001); Levitt and Gabel, California Health Benefits Survey 2000 and Wm. Mercer Inc. Employer Sponsored Health Insurance: A Survey of Small Employers in California (CA Health care Foundation, Aug. 1999)
[38] See Meyer and Wicks, A Federal Tax Credit to Encourage Employers to Offer Health Coverage and Pauly and Herring, Expanding Coverage via Tax Credits: Trade Offs and Outcomes
[39] California previously enacted and then repealed a small and untargeted tax credit, which was not well designed to reach the uninsured. See discussion of SB 1207 (Keene) in Wulsin, California at the Crossroads (Center for Governmental Studies (1994) at p. 85. See Franchise Tax Board Analysis of AB 39 (Thomson and Campbell) at www.ftb.ca.gov.
[40] See Silow-Carrol, State and Local Initiatives to Enhance Health Coverage of the Working Uninsured and D. Helms et al., Mending the Flaws in the Small Group Market, Health Affairs (Summer, 1992).
[41] Levitt and Gabel, California Health Benefits Survey 2000.
[42] Phone interview with Employment Development Department. Professor Kronick's research on FOCUS in San Diego suggests that about 80,000 uninsured full time employees work for uninsuring small employers of less than 50 employees and make less than $12 an hour. This was about 12% of San Diego's total uninsured. R. Kronick and D. Strom, Survey of FOCUS Program, Report of Findings
[43] For example, if the subsidy cut off is set at 10 employees, 12% of the workforce is affected and the subsidy may set a disincentive for an employer with 10 employees to hire a new employee and lose the 50% premium subsidy on the other low wage employees.
[44] See Schauffler and Brown, The State of Health Insurance in California, 1999.
[45] Health and Safety Code §1345
[46] A recent list of California's mandates to offer, to cover and to include particular providers can be found in Wulsin et al, California's Uninsured: Programs, Funding and Policy Options (ITUP, January, 1998) at www.work-and-health.org/itup/reports.
[47] While we believe the approach is promising, no state has yet reported a breakthrough in increasing employment based coverage. See Sharon Silow-Carroll et al, Expanding Employment Based Health Coverage: Lessons from Six State and Local Programs (Commonwealth Fund, Feb. 2001) at www.cmwf.org.
[48] Brown, The State of Health Insurance 2000, and Levitt, California Health Benefits Survey 2000 (Kaiser Family Foundation, 2001).
[49] See Acs and Blumberg, How a Changing Workforce Affects Employer Sponsored Coverage, Health Affairs (Jan-Feb. 2001) and Bilheimer and Colby, Expanding Coverage: Reflections on Recent Efforts, Health Affairs (Jan-Feb. 2001)
[50] California Budget Project, The State of Working California: Income Gains Remain Elusive for Many California Workers and Families (9/3/2001)
[51] J. Medoff et al, How the New Labor Market is Squeezing Workforce Health Benefits (Center for National Policy, June 2001) at www.cmwf.org.
[52] Mark Merlis, Public Subsidies for Required Employee Contributions Toward Employer Sponsored Health Insurance (Institute for Health Policy Studies, Dec. 2000) Average employee contributions for single coverage grew from $8 a month in 1988 to $35 a month in 1999; for families the contribution increased from $52 a month to $145.
[53] See Jon Gabel et al., Embraceable You: How Employers Influence Health Plan Enrollment, Health Affairs (July-Aug. 2001)
[54] Brown, The State of Health Insurance 2000

[55] L. Blumberg and L. Nichols, The Working Uninsured In California (Urban Institute and Kaiser Family Foundation, 2001).
[56] Resource Group, Small Business Health Insurance Coverage, 1999
[57] See H. Greenwald et al, Califomia's Working Latinos and Health Insurance: New Facts and Policy Challenges (Univ. of So. Cal. School of Public Administration, Oct. 2001). The small number of workers in this study who declined to take up an employer's offer of coverage reported less ability to speak with providers, greater satisfaction with public or free clinics and shorter times of stay in the US.
[58] California Health Care Foundation, To Buy or Not to Buy: A profile of California's Non-Poor Uninsured (1999) at www.chcf.org .
[59] See L Zelenak, A Health insurance Tax Credit for Uninsured Workers Commonwealth Fund, Dec. 2000) at www.cmwf.org and Merlis, Public Subsidies for Required Employee Contributions Toward Employer Sponsored Health Insurance.
[60] California Budget Project, How Can A State Earned Income Tax Credit Help California's Working Poor Make Ends Meet (3/01) at www.cbp.org.
[61] See n. 12
[62] Katherin Phillips, Who Knows about the Earned Income Tax Credit (Urban Institute, Jan. 2001)
[63] Insurance Code §12693.15 and 12693.27
[64] Brown, The State of Health Insurance 2000. The public coverage rates of mixed status families fell significantly between 1994 and 1999.
[65] Wulsin et al, Developing Models of Coverage for the Flex Workforce (ITUP, 2000) p. 2 available at www.work-and-health.org/ITUP
[66] Acs and Blumberg, How a Changing Workforce Affects Employer Sponsored Health Insurance, Health Affairs ((Jan. Feb, 2001) and Jon Gabel et al, Embraceable You: How Employers Influence Health Plan Enrollment, Health Affairs (July Aug. 2001)
[67] Wulsin, Coverage for the Flex Workforce p. 1 and 12
[68] Ibid. For example, 6% of temporary workers had coverage through their own employers and nearly 45% through spouses and 16% of part time workers had coverage through their own employers and 36% through spouses.
[69] Ibid.
[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] Employment Policy Foundation - Employment Trends - Temporary Work, A Catalyst for a Stronger Economy - Krishna Kundu: June 15, 2000. www.epf.org
[74] National Coalition on Health Care - Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States - Findlay & Miller: May 1999. www.americashealth.org/releases/erosion.html
[75] California Employment Development Department, Labor Market Information, Self Employment in California 1999 (Oct. 2000) at www.calmis.ca.gov
[76] Wulsin, Coverage for the Flex Workforce
[77] See n. 2.
[78] Wulsin, Coverage for the Flex Workforce
[79] Congress and the Administration are now considering proposals for between $3 and $8 billion annually to pay for health insurance for the newly unemployed. R. Pear, Bills Would Help New Jobless Keep Insurance, New York Times, (10/14/01) p. A-16. A variant on this approach is to finance transitional coverage through a short term government loan, which would be repayable in installments once the individual is again covered through employment based coverage and forgiven for employees with income below a certain income threshold such as 300% of FPL. See J. Gruber, Transitional Studies for Expanding Health Coverage (Nat'l Bureau of Economic Research, Dec. 2000) available at www.cmwf.org.
[80] See Curtis et al, Expanding Healthy families to Cover Parents: Issues and Analyses Related to Employer Coverage (Institute for Health Policy Solutions, Jan. 2001). Rick Curtis makes the salient point that coverage is more directly linked to wage levels than to family income; thus a family with two wage earners making $12,500 each is less likely to be insured than a family with a single wage earner making $25,000. We may be able to achieve more cost effective targeting of tax credits by linking them to wages than to family income. This is a difficult concept for those accustomed to public programs that link eligibility to family income.

[81] See HIPC/PacAdvantage rates effective 1/1/01. In Los Angeles, the low rate for small business employees 30-40 is $106, for employees 50-54 it is $167, for employees 60-64 it is $255. The proposed federal legislation sets the tax credit at $1000-1200 per adult and $2400-3600 per family. See e.g. HR 1136 (Norwood) and HR 2261 (Johnson)
[82] See Health Insurance Flexibility and Accountability Demonstration Projects at www.hcfa.gov/medicaid/hifademo.
[83] PacAdvantage Rates Effective 1/1/2001
[84] See e.g. HR 2261 (Johnson) and S2320 (Jeffords)
[85] California Budget Project, Who Pays Taxes In California (April 2001) at www.cbp.org.
[86] See discussion of the pros and cons of federal tax credit proposals by J. Frogue, A Guide to Tax Credits for the Uninsured (Heritage Fdn., May 5, 2001) at www.heritage.org and I. Lav, Tax Credits for Individuals to Buy health Insurance Won't Help Many Uninsured Families (Center on Budget and Policy Priorities, Feb. 2001) at www.cbpp.org.
[87] See n. 17.
[88] We are recommending a longer (12 months) pre-existing condition exclusion and a broader rate band for health status than the small group market reforms to account for adverse selection. The 25% adjustment for health status is comparable to the MRMIB premiums for the medically uninsurable.
[89] Brown et al, The State of Health Insurance 2000
[90] Ibid. Those with minor children are eligible for but unenrolled in MediCal and will be eligible once the federal waiver is approved. Brown estimates that half are single adults without minor children and 13% are couples without minor children.
[91] Ibid.
[92] See R. Kronick et al. Expansion of Health Care to the Working Poor: Lessons from Other States (CA Policy Research Center, 1999)
[93] See Health Insurance Flexibility and Accountability Demonstration Projects at www.hcfa.gov/medicaid/hifademo. These guidelines give strong guidance that the waiver requests should not exceed 200% of FPL and should not tamper with the basic minimum Medical eligibility such as coverage for SSI eligibles and children up to age 6 and up to 133% of FPL.
[94] See Wulsin at al: California's Uninsured: Programs, Funding and Policy Options (Insure the Uninsured Project, July 1997) available at www.work-and-health.org/itup.
[95] Counties such as San Francisco, Alameda and Santa Clara are using their Local Initiatives as a building block to cover segments of the uninsured. In San Diego, local managed care organizations such as Sharp and Community Health Group are acting as the focal points of local efforts to cover the uninsured. In Orange and San Mateo Counties, the County Organized Health Systems may serve as the building blocks. See Wulsin et al, Insure the Uninsured Project Conference Binders 1999 and 2001, Tabs on County, Clinic and Local Initiative Efforts to Cover the Uninsured available at www.work-and-health.org/itup.
[96] 2000 Summary of County Medical Services Program Expenditures (CMSP Governing Board, 8/30/01
[97] Ibid.
[98] M. Hickey, An Overview of the Uninsured in Northern Rural California (ITUP, Sept. 28, 2001) available at www.work-and-health.org/itup.
[99] Ibid. Self pay accounted for 27% of clinics' uninsured revenues, EAPC and other state programs for 37%, CMSP and other county programs for 28% and CHDP for 9% of clinics' uninsured revenues.
[100] As a rule of thumb, CMSP counties account for 10% of the state's uninsured.
[101] Peter Long, An Overview of California Financing and Coverage (ITUP, Sept. 28, 2001).
[102] Hickey, An Overview of the Uninsured in Northern Rural California. In the other nine study counties, MediCal accounted for disproportionate emergency room visits. In Solano, possibly due to its COHS, MediCal emergency room visits were proportionate.
[103] See Wulsin et al, Clinics, Counties and the Uninsured (Insure the Uninsured Project, 1999).
[104] Hickey, An Overview of the Uninsured in Northern Rural California
[105] Wulsin et al, Clinics, Counties and the Uninsured
[106] For example there have been extensive discussions of Cal Optima managing care and coverage for the medically indigent adults in Orange County; the principal obstacle is financing, which could be solved with a waiver. See Roohe Ahmed, An Overview of the Uninsured in Orange and San Diego Counties (ITUP, Oct. 2001).

[107] For example, in analyzing county efforts to care for the uninsured, we discovered large discrepancies between Orange and San Diego County's own data for the county programs for the medically indigent and the data reported by the county to the state's MICRS (Medically Indigent Care Reporting System). This would change the number of uninsured seen in a county system by a factor of three hundred percent. The discrepancy results from the reporting of episodic emergency room care to the uninsured paid for by the county under Prop 99 together with the county data for the costly chronically ill and seriously injured using the county system for indigent adults. See Wulsin et al. Clinics, Counties and the Uninsured: Phase One (Insure the Uninsured Project, 1999). See also Roohe Ahmed, An Overview of the Uninsured in Orange and San Diego Counties.
[108] Wulsin et al. Clinics, Counties and the Uninsured: Phase Two (Insure the Uninsured Project, 2000)
[109] Ibid.
[110] For example in Fresno, most of the funding is directed to a single community hospital, which has taken over the responsibilities of the old county hospital. In San Diego, community clinics are the sole contracted source of primary care.
[111] Wulsin, Clinics, Counties and the Uninsured: Phase One
[112] Office of Statewide Health Planning and Development, Individual Hospital Financial Data for California: Report Periods July, 1997-June, 1998.
[113] Clinics, Counties and the Uninsured: Phase Two
[114] Ibid.
[115] See D. Greiff and Wulsin, Improving Care for Uninsured High Utilizers in Public and Private Health Delivery Systems (Dec. 2000) (unpublished manuscript)
[116] The use of outpatient care is far lower than for an insured population, while the use of hospital services is far higher.
[117] The COHS programs in Orange and Santa Barbara and the managed care plans in San Diego have wide experience in managing care for the uninsured and/or the chronically ill portions of MediCal.
[118] Clinics, Counties and the Uninsured: Phase One and Phase Two
[119] Clinics, Counties and the Uninsured: Phase One.
[120] Children comprise roughly 10% of county uninsured spending, and in Los Angeles the undocumented account for an estimated 11-12% of county uninsured spending. Ibid.
[121] Ibid.
[122] Clinics, Counties and the Uninsured: Phase Two
[123] Clinics, Counties and the Uninsured: Phase One
[124] Clinics, Counties and the Uninsured: Phase Two
[125] Ibid.
[126] Clinics, Counties and the Uninsured: Phase One
[127] Indigent/Bad Debt Net Surplus or Deficit 1995-6 and SB 855 Revenues (Los Angeles County Dept. of Health Serv. 10/97)
[128] Insure the Uninsured Project, Conference Binder 1999, Counties, Local Initiatives Tab available at www.work-and-health.org/itup/conference.
[129] Data on county users and county spending derived from county reports to California Department of Health Services and reported at Clinics, Counties and the Uninsured. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000. We have one year more recent county data reported in Wulsin, the Chronically Ill Uninsured (ITUP, Dec. 2000). The Alameda count of unduplicated users increases to 58,000; the Los Angeles County report on unduplicated users falls to 649,000 and spending on the uninsured falls to $730 million; Santa Clara County's reported unduplicated users increases to 69,000 and spending to $85 million. This use data is from 1997-8 and the budget data from 1999-2000.
[130] Data on county hospital days and visits derived from county reports to California Department of Health Services as revised by the counties and reported at Clinics, Counties and the Uninsured. Data on county uninsured and unlinked, uninsured adults derived from Brown, The State of Health Insurance 2000. We have one year more recent county data reported in Wulsin, the Chronically Ill Uninsured. Alameda County hospital days increase to 17,500 and emergency room visits fall to 8,500; Los Angeles County hospital days fall to 201,000, emergency room visits fall to 163,000 and outpatient visits increase to 1,544,000; Santa Clara county hospital days increase to 14,600, emergency room visits fall to 23,000 and outpatient

visits fall to 146,600. This county reported use data is from 1997-8 and has not been revised by the counties.

[131] See Wulsin et al. Clinics, Counties and the Uninsured: Phase Two (Insure the Uninsured Project, 2000). Public safety net providers depend on realignment, Prop 99 and DSH (disproportionate share hospital) funding; non profit community clinics depend on EAPC, CHDP and federal grants and contracts; private hospitals depend on DSH, and private doctors depend on SB 12, Prop 99 and patient copayments. State programs such as Family PACT and Breast Cancer Treatment and stand alone MediCal coverage for perinatal care may need to be merged into the system we are proposing. None of the funding streams are now connected to a coherent delivery and financing system. There are also transitional challenges in coordinating with the MediCal programs for the disabled as county eligibility is often the "waiting room" while MediCal eligibility for disability is being assessed.

[132] MediCal managed care is based on a primary care doctor while care to the uninsured is often funneled and managed through a public hospital emergency room or outpatient department.

[133] See n. 5.

[134] P. Long, An Overview of California Financing and Coverage (ITUP, Sept. 2001).